DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 2 0

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 02 $ _____
b. FFY 03 $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Pages 1a & 2 and Appendix A Pgs 1, 2, & 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Pages 1a & 2 and Appendix A Pgs 1, 2, & 3

10. SUBJECT OF AMENDMENT: Establish a prospective paymentsystem for outpatient hospital ervices and eliminate the requirement to calculate finalsettlements for hospitals hich were operating prior to January 1, 1999 and continue to operate after uly 1, 2002.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
7/25/02

16. RETURN TO:
Missouri (02-020)
approved: 10/22/02
effective: 07/01/02

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 07/26/02

DATE APPROVED: OCT 22 2002

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/02

SIGNATURE OF REGIONAL OFFICIAL:

TYPED NAME: Thomas W. Lenz

TITLE: ARA for Medicaid & State Operations

REMARKS:

SSA CONTROL
Date Submitted: 07/25/02
Date Received: 07/26/02

FORM HCFA-179 (07-92)

Instructions on Back

STATE: Missouri

OPTOMETRIC SERVICES

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the Division of Medical Services. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CRF 447 Subpart D. Agency payment will be the lower of :

(1) The provider's actual charge for the service; or
(2) The allowable fee based on reasonable charge as above determined.

The state agency will reimburse providers of any Optometric Services a may be covered under Medicare Part B, to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

I Prospective Outpatient Hospital Services Reimbursement methodology for Hospitals Located Within Missouri.

A Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002 except for services identified in subsection I.C. The prospective outpatient payment percentage will be calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999.) The prospective outpatient payment percentage shall not exceed one hundred percent (100%) except for nominal charge providers and shall not be less than twenty percent(20%).

B Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports.

C Outpatient hospital services reimbursement limited by rule.

1. All services provided to General Relief (GR) recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-15.020.
2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.
3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on a CMS-1500 professional claim form, which is incorporated by reference as part of this rule, and reimbursed from a Medicaid fee schedule or the billed charge, if less.
4. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

II Exempt Hospitals. Medicaid providers which do not have a fourth, fifth and sixth prior year cost report.

A Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three state fiscal years in which the hospital operates. The cost reports for these three (3) years will have a cost settlement calculated in accordance with Attachment 4.19B, Appendix A.

B Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

III Closed facilities. Hospitals which closed after January 1, 1999 but before July 2, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with Attachment 4.19B Appendix A.

IV Definitions

A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the form utilized in filing the cost report.

C Effective date.

1. The plan effective date shall be July 1, 2002.
2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

I. Outpatient hospital settlements, Provider-Based Rural Health Clinic (PBRHC) settlements or Provider-Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the Division receives the Medicare/Medicaid cost report with a Notice of Provider Reimbursement from the hospital Fiscal Intermediary. Outpatient settlements shall not be determined for cost report periods ending after December 31, 1998 except for recently closed hospitals and new hospitals as provided for in subsection I.E.

A. The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC/PBFQHC Medicaid payments (except for those hospitals that qualify under subsection I.B., whose payments will be based on the percent of cost in I.A.1., 2, 3 or 4. for:

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection I.D., or eighty percent (80%) of the outpatient charges from paragraph I.C.1.,;

2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection I.D., or ninety percent (90%) of the outpatient charge from paragraph I.C.1.;

3. Services after March 31, 1998, included in cost reports ending prior to January 1, 1999 the lower of one hundred percent (100%) of the outpatient share of the cost from subsection I.D, or one hundred percent (100%) of the outpatient charge from paragraph I.C.1; and.

4. PBRHC and PBFQH shall be reimbursed 100% of its share of the cost in subsection I.D.

B. A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in subsection I.A.1., 2 or 3.

C. The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be:

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under Attachment 4.19B

2. For provider based PBRHC and PBFQHC the charges and payments will be services billed under Attachment 4.19B, page 8 for FQHCs and page 44 for PBRHCs.

D. The Medicaid hospital's outpatient cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph I.D.1., by the Medicaid charges from paragraph I.C.1. To this product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (CMS 2552-96) by substituting Medicaid data in place of Medicare data:

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center excluding PBRHC or PBFQHC on the supplemental worksheet C column 1 (CMS 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (CMS 2552-96) column 7 part I of the fiscal intermediary's audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center that is reimbursed on a percentage of charge basis by Medicaid under Attachment 4.19B. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

E. The Medicaid outpatient final settlements for cost reports ending prior to January 1, 1999 unless the hospital closed prior to July 1, 2002, will determine either an overpayment or an underpayment for the hospital's outpatient services:

1. The outpatient Medicaid cost determined in section I.D. is multiplied by the percent of cost allowed in paragraph I.D.1., 2., or 3., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under Attachment 4.19B for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments, coinsurance and deductibles.) The difference is either an overpayment (negative amount) due from the provider or an underpayment (positive amount) due to the provider.

2. Closed facilities. Hospitals which closed after January 1, 1999 but before July 1, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040(4)(E)1; and

3. New hospitals which do not have a fourth, fifth, and sixth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three cost report periods.

F. The Medicaid PBRHC or PBFQHC final settlement will determine either an overpayment or an underpayment for the hospital's PBRHC or PBFQHC services. For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or an underpayment (positive amount) due to provider.